WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

**PLACE OF DEATH**

County Dunklin

Township Freeborn

or

Village

or

City (NO. St.; Ward)

Registration District No. 284 File No. 20 31470

Primary Registration District No. 5403 Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME J. W. Franklin Mann

**PERSONAL AND STATISTICAL PARTICULARS**

SEX Male

COLOR OR RACE White

SINGLE ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)

DATE OF BIRTH Sept 4, 1916 (Month) (Day) (Year)

AGE 1 yrs. — mos. — ds.

If LESS than 1 day, ..... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Clarkton Mo

PARENTS

NAME OF FATHER Frank Mann

BIRTHPLACE OF FATHER (City or town, State or foreign country) Ark

MAIDEN NAME OF MOTHER Louis Bell Neeley

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ark

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Neeley

(ADDRESS) Clarkton

Filed Oct. 17, 1917. J. F. Brooks REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH Sept 4, 1917 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug. 24, 1917, to Sept 3, 1917, that I last saw him alive on Sept 3, 1917, and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

1196

104

(Duration) yrs. mos. 14 ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) [signature] M. D.

Sept 6, 1917 (Address) Bloomfield Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Stanfield Cemetery

DATE OF BURIAL Sept 5, 1917

UNDERTAKER M. W. Hubbard

ADDRESS Clarkton Mo

# Revised United States Standard Certificate of Death

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name

**MISSOURI STATE BOARD OF HE**
**BUREAU OF VITAL STATISTICS**
**CERTIFICATE OF DEATH**

**PLACE OF DEATH**

County .....

Township ..... Registration District No. ..... File No. .....
*or*
Village ..... Primary Registration District No. ..... Registered No. .....
*or*
City ..... (NO. ..... St.; ..... Ward)

[If death o hospital or give its NA of street an

**FULL NAME** .....

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

DATE OF BIRTH ..... (Month) ..... (Day) ..... (Year)

AGE ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ..... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE (City or town, State or foreign country)

PARENTS
- NAME OF FATHER
- BIRTHPLACE OF FATHER (City or town, State or foreign country)
- MAIDEN NAME OF MOTHER
- BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ..... 191.... .....

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH ..... (Month) ..... (Day)

I HEREBY CERTIFY, that I attended dece ..... , 191.... , to ..... that I last saw h ..... alive on ..... and that death occurred, on the date stated above, at ..... The CAUSE OF DEATH* was as follows:

..... (Duration) ..... yrs. ..... mos.

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos.

(Signed) .....

..... 191.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent C (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

| PLACE OF BURIAL OR REMOVAL | DATE OF BUR |
|---|---|
| UNDERTAKER | ADDRESS |